Certified Community Behavioral Health Clinics and Federally Qualified Health Centers: A qualitative analysis of relationships between Medicaid-funded community behavioral healthcare models in Michigan

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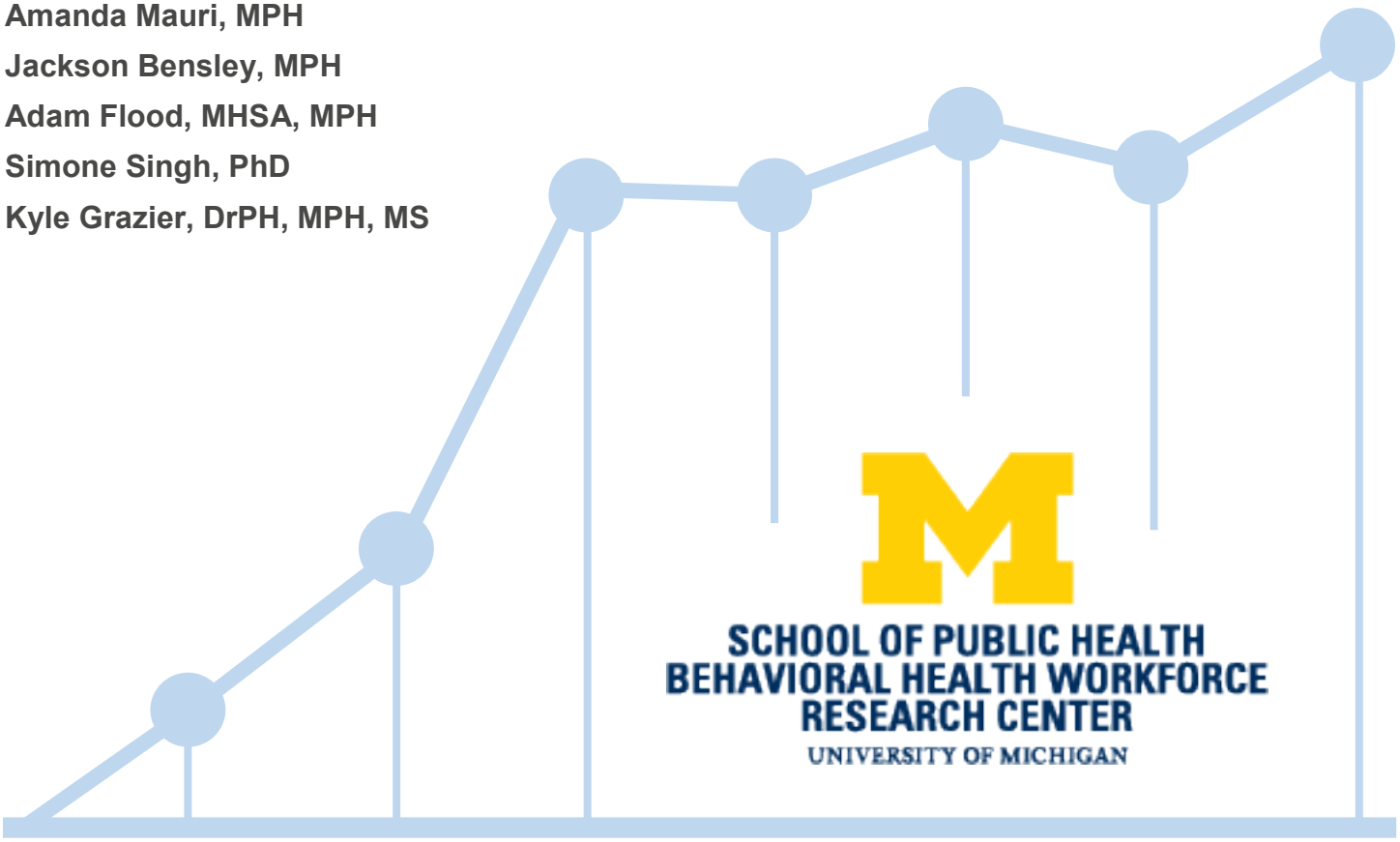

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Introduction

Certified Community Behavioral Health Clinics (CCBHCs) and Federally Qualified Health Centers (FQHCs) are both community-based healthcare providers primarily funded through Medicaid.[1] Among other federal criteria, CCBHCs are non-profit entities or units of a local government behavioral health authority that offer nine categories of mental health, substance use, and primary care services; coordinate their care with medical and social service providers; and provide care regardless of ability to pay.[2] FQHCs and their look-alike peers are organizations that serve an underserved area or population; offer a sliding fee scale; and provide comprehensive services, such as preventive health services, dental services, and behavioral health services.[3]

CCBHCs are required to coordinate their care with FQHCs. Specifically, CCBHCs must establish "care coordination expectations with FQHCs (and, as applicable, Rural Health Clinics [RHCs]) to provide healthcare services, to the extent the services are not provided directly through the CCBHC."[4] Care coordination arrangements can take the form of an informal agreement (e.g., letter of support, agreement, or commitment), though formal agreements (e.g., contracts, Memorandum of Agreement, Memorandum of Understanding) are preferred. CCBHCs may also choose to partner with an FQHC through a designated collaborating organization (DCO) arrangement. DCOs are entities that CCBHCs contract with to provide one of the five service categories CCBHCs are required to offer but are allowed to provide through another organization.

To date, the design and purpose of existing CCBHC–FQHC relationships remain relatively unknown. The existing literature on CCBHCs and FQHCs partnerships resides in reports by the United States Department of Health and Human Services (HHS) to Congress.[5] The relevant data from these reports are limited to counts of the number of CCBHCs that have a DCO or other formal or informal relationship with FQHCs, RHCs, and other primary care providers. The reports demonstrate that CCBHCs have DCO or care coordination arrangements with FQHCs, and that some CCBHCs offer on-site primary care services in addition to primary care screening and monitoring, which is one of the nine service categories CCBHCs are required to provide.[6] Oregon has gone a step further, mandating that sites provide 20 hours of on-site primary care services per week in the second demonstration year. These findings suggest that the relationship between CCBHCs and FQHCs is further complicated by the fact that some CCBHCs may offer on-site primary care in addition to the mandated nine categories of CCBHC services.

Findings from the HHS reports are limited to the subset of CCBHCs enrolled in the Section 223 Demonstration Program, who receive an enhanced Medicaid rate for qualifying patient encounters. The reports do not provide any information on CCBHCs that do not participate in the Section 223 Demonstration but have received SAMHSA expansion grants, that is, lump sum rewards to support infrastructure costs, like staffing, equipment, supplies, training, and rent.[7] To fill this gap in knowledge, this project explores the relationships between CCBHCs and FQHCs including both CCBHCs enrolled in the Section 223 Demonstration Program and CCBHCs with SAMHSA expansion grants. We answer two questions. First, what is the structure of arrangements between CCBHCs and FQHCs? By structure we refer to the formalization, location, and origin of CCBHC–FQHC arrangement. Our second question asks, what is the purpose (e.g., primary care or behavioral health referrals, primary care screening) of FQHC–CCBHC partnerships?

Methods

Study Design

Our goal was to recruit CCBHCs and FQHCs to understand the structure and purpose of their relationship with each other. As this is the first in-depth analysis of CCBHC–FQHC partnerships, we limited our project to the state of Michigan, which is a Section 223 Medicaid Demonstration state but also contains numerous CCBHCs participating in the Substance Abuse and Mental Health Services Administration (SAMHSA) Expansion Grant program. Thus, Michigan provides an opportunity to examine arrangements

between FQHCs and three types of CCBHCs: (1) CCBHCs participating in both the Section 223 Demonstration and the SAMHSA Expansion Grant programs, (2) CCBHCs participating in the Section 223 Demonstration only, and (3) CCBHCs participating in the SAMHSA Expansion Grant program only.

We employed a purposive sampling approach to generate our samples of CCBHCs and FQHCs. We contacted all CCBHCs in the state of Michigan, ensuring that our final sample was representative of the eight Prepaid Inpatient Health Plans (PIHPs) in Michigan with CCBHCs.[8] The two PIHPs in the northern part of the state do not contain any CCBHCs. For our CCBHC sample, we further ensured that we interviewed at least 25% of clinics within the three types of CCBHCs based on federal program participation. For our FQHC sample, we contacted all FQHCs in Michigan with publicly available e-mail addresses or contact forms. The Institutional Review Board at the University of Michigan approved this study.

Data Collection and Analysis

From February to March 2022, we conducted 1-hour, semi-structured interviews (n=13) over Zoom with CCBHC administrative leadership (e.g., chief executive officers [CEOs], chief operating officers [COOs], presidents, CCBHC administrators, directors of clinical or integrated care). We conducted 30-minute, semi-structured interviews with FQHC administrative leadership in July 2022. The interview protocol included two domains related to CCBHC–FQHC partnerships: (1) arrangement design and (2) arrangement purpose. We pilot tested the interview guide with representatives from a CCBHC and an FQHC and iteratively refined the guide in subsequent interviews. Interviews of CCBHCs were completed when saturation was reached. Interviews with FQHCs were limited to the respondents of our e-mail outreach.

All interviews occurred and were recorded using Zoom (Version 5.11.3. [9065], Zoom Video Communications, Inc.). We had the interview data transcribed using Scribie.com's transcription services and then transferred to Dedoose (Version 9.0.54, Dedoose). We employed an inductive and iterative thematic analytical approach. We developed a preliminary code book by reviewing three interview transcripts. Research team members met to discuss and refine the codebook. Two research team members then independently coded all interviews and met to discuss and resolve discrepancies. The research team met biweekly to discuss the coding process, including codebook revisions and key themes.

Results

Sample Characteristics

We interviewed 13 of the 35 CCBHCs in Michigan. Our sample included 45% of clinics (n=5) that participate in both the Section 223 Demonstration program and received a SAMHSA Expansion grant, 100% of clinics (n=2) that only participate in the Section 223 Demonstration program, and 27% of clinics (n = 6) that received a SAMHSA Expansion award but do not participate in the Demonstration program. We interviewed a minimum of 25% of clinics within the eight PIHPs with a CCBHC with the exception of Region 7 (Wayne County, which contains the city of Detroit) and Region 6. Region 6 contains one CCBHC, which served as our pilot interviewee. See Table 1 for the distribution of CCBHC federal program participation types by PIHP.

Table 1: Number of CCBHCs interviewed for this project and total CCBHCs in Michigan by PIHP and Federal Program Participation

PIHP	Total	Section 223 Demo	SAMHSA Expansion	Both
3	3/5	0/0	2/3	1/2
4	2/6	1/1	0/4	1/1
5	2/4	1/1	1/1	0/2
6	1/1	0/0	0/0	0/1
7	3/13	0/0	2/12	1/1
8	1/4	0/0	0/2	1/2
9	1/1	0/0	0/0	1/1
10	1/2	0/0	1/1	0/1
Total	**13/35**	**2/2**	**6/23**	**5/11**

We contacted all FQHCs in Michigan with publicly available e-mails addresses or contact forms who reside in a PIHP with a CCBHC (n=23). Although we sent interview invitations at least twice to all potential

FQHC participants, only three FQHCs responded to our interview invitation. Two FQHCs we interviewed reside in PIHP 7 and the other in PIHP 5.

Partnership Structure

In this section, we present our findings regarding the structure of the CCBHC–FQHC partnerships from the vantage point of our CCBHC interviewees. We find that a majority of Michigan CCBHCs have established formalized care coordination arrangements with FQHCs. These partnerships commonly existed prior to the clinic becoming a CCBHC. Partnerships vary based on a number of factors, including whether or not the relationship involves co-location or shared clinic hours and electronic health record (EHR) integration.

Care Coordination Arrangement or Designated Collaborating Organization

The majority of Michigan CCBHCs have formalized arrangements in place with FQHCs. All interviewees representing clinics that participate in the Section 223 Medicaid Demonstration have arrangements in place with FQHCs or rural health clinics. Among CCBHCs that received a SAMHSA Expansion award but do not participate in the Section 223 Demonstration, half have formalized partnerships with FQHCs. Several interviewees mentioned that they have multiple arrangements at the organizational level, so that each CCBHC partners with at least one FQHC relevant to their patient population.

All CCBHCs with FQHC partnerships, except one, formalize their arrangements through care coordination arrangements in the form of a memorandum of understanding or agreement. The one exception was a CCBHC that is part of a larger organization that also contains an FQHC. Their FQHC served as a co-applicant for their SAMHSA Expansion grant, and since they already have a financial relationship with the FQHC, they chose not to further formalize their partnership through a memorandum of understanding, contract, or other mechanism to meet the CCBHC care coordination requirement. In addition to care coordination agreements with FQHCs, two CCBHCs that participated in both the Section 223 Demonstration and received a SAMHSA Expansion grant also have DCO arrangements with FQHCs.

The three clinics that had yet to establish formalized FQHC partnerships are relatively new CCBHCs, having only received their SAMHSA Expansion awards in 2021. All three CCBHCs expressed interest and discussed plans to formalize these arrangements. A behavioral health programs manager described that "right now we are working on getting those in place with FQHCs." A CCBHC program supervisor explained, "They are very busy, so trying to get an agreement in place with them right now has been a little bit of a challenge, but we're forging ahead… We have a handshake agreement at the moment."

Co-location

The majority of the interviewees describe their CCBHC–FQHC formalized partnerships as involving co-location or nearby access with same-day appointments. Co-location takes the form of daily or a set number of clinic hours and days in the same location. Some clinics expressed interest in further expanding these arrangements. For instance, the executive director of a CCBHC that partners with an FQHC to run an on-site clinic 1 day a week described conversations to expand the clinic to 2 days a week.

CCBHCs with partnerships but no co-location or nearby access shared that they were interested in facility sharing but faced challenges in establishing or sustaining co-location. A COO stated that they had "offered to have staff co-located… to do screenings and things like that, but they just haven't been responsive." The same interviewee described that they had a co-located arrangement for several years, but "never quite got up to the number of shared patients that they needed to sustain the location." A CCBHC administrator mentioned that they moved the FQHC clinic hours from their facility to the FQHC's facility during the coronavirus disease 2019 (COVID-19) pandemic to accommodate social distancing and are currently figuring out how to best structure this arrangement.

Continuation of Existing Partnerships

Interviewees revealed that many of their clinic's arrangements with FQHCs are continuations of existing partnerships. Three interviewees said that at least one of their CCBHC–FQHC arrangements originated with a previous SAMHSA grant for primary behavioral healthcare integration. Three other organizations described that their partnerships had "happened long before our CCBHC" or that the FQHC was their "long-time partner," demonstrating that many CCBHCs had arrangements in place with FQHCs prior to the CCBHC care coordination requirement.

Electronic Health Record Integration

No Michigan CCBHC–FQHC partnership involved EHR integration. As a COO mentioned, "...it's primarily conversations, and still old-fashioned faxing data… because we don't have a bridge between their EMR and our EMR." A CEO concurred: "One of our goals is to have our EHR talk directly to other EHRs... So we can send in terms of pharmacy, like scripts, all that can happen via the EHR, but not as easily in terms of sharing records." Despite no EHR integration, a CCBHC administrator mentioned that they have shared access, meaning that the CCBHC clinical staff can access the FQHC's EHR and vice versa.

The interviewee representing the CCBHC with an FQHC co-applicant plans to use some of their SAMHSA Expansion grant funding to achieve EHR integration. Despite sharing a patient population of approximately 1,000 patients, until the two EHRs "...can talk to each other," the participant believed that her organization cannot accomplish population health management. Consequently, part of their Expansion grant funds "is going towards upgrading their (the FQHCs) product, so it can interact with our (the CCBHC's) health information exchange."

Partnership Purpose

This section discusses the utility of the CCBHC–FQHC relationship from the perspective of participating Michigan CCBHCs. Generally, our interviewees shared that the primary purpose of the partnership is primary care referrals, although some CCBHCs also refer less complex behavioral health patients to an FQHC partner. These referrals have become less common since clinics have become a CCBHC. CCBHCs report that FQHCs refer patients to CCBHCs, but these referrals tend to happen less frequently than the reverse and concern patients with complex or severe mental health disorders. FQHCs and the majority of CCBHCs treat patients with less complex and acute mental health conditions and substance use disorders.

Referrals from CCBHCs to FQHCs

All CCBHC interviewees consistently noted that the primary purpose of their care coordination arrangement with FQHCs is primary care referrals. The COO of a CCBHC stated, "we use our FQHC to connect patients with a provider." A CEO of another CCBHC stated, "we use them a lot to establish new primary care physicians." Some CCBHC interviewees also noted that prior to becoming a CCBHC, they would refer patients with less complex behavioral health conditions or patients only needing medication treatment to their FQHC partner. However, these referrals are happening less frequently as a result of the expanded capacity associated with becoming a CCBHC. One CEO described this trend: "we would see them here as a request for service, and (if) they were more of a mild or moderate, we would do a warm hand-off… Versus now… we provide the care that we were not able to before." Another interviewee expressed a similar change: "we tried to transfer our graduating people over to them to get their meds… (but) especially with this CCBHC, we were able to keep them. 'Cause we can serve mild to moderate all the way to severe."

Referrals from FQHCs to CCBHCs

Organizations differed on the frequency of referrals from FQHCs to CCBHCs. Some interviewees expressed that these referrals are rare: "they don't have very many people that are coming into that facility that are seeking medical treatment and then needing behavioral health. If they do, yeah, they would refer to us. But that happens so rarely." By contrast, others communicated that "back and forth (happens) all the

time."

Despite differences in frequency, interviewees similarly expressed that when referrals from FQHCs to CCBHCs occur, patients tend to be complex or severe patients with mild and moderate mental health patients and individuals with substance use disorders served directly by or referred back to the FQHC. As illustrated by a COO of a CCBHC, "They directly serve the mild to moderate, so if somebody comes to them and they have a mild to moderate condition, they just serve them there. But if somebody has a more severe condition, they're not contracted to provide services, so they refer them to us." A CEO of another CCBHC described, "sometimes they get patients, and they try to stabilize them on meds, can't do it. They call us, they send them over here and then we stabilize them and then give them back… If it's too complicated of a medication regimen, then we tend to keep them."

Primary Care Screening and Monitoring

All CCBHCs must directly provide or contract with a DCO to offer "outpatient clinic primary care screening and monitoring of key health indicators and health risks." All interviewees, regardless of whether they had an FQHC arrangement, report that they directly provide some or all required primary care screening and monitoring services. A COO of a CCBHC described, "we're doing some screenings on-site, based on what we're required to screen for." A CEO of another CCBHC stated, "we have decided to provide our health screenings for ages 3 and up." A CEO representing an organization with both a care coordination agreement and a DCO–FQHC partnership communicated that they use their DCO partner for screening services at some clinics but offer screening directly at others. Specifically, they pay an FQHC "through the grant… to do those physical health screenings." At the same time, they "hired a new nurse practitioner who has a credential for psychiatry…, and a portion of her time will be devoted to those physical health screenings." However, the CEO communicated that they plan to change this arrangement from a DCO to a care coordination agreement, implying that the DCO FQHC will no longer provide primary care screening services.

Other Primary Care Services

Nearly all CCBHCs interviewed for this project with and without FQHC partnerships do not offer other primary care services beyond screening and monitoring. A director of clinical services explained, "there's definitely a need just for people to be able to come in and access general primary care health needs, but we're not currently doing that." The chief program officer of another CCBHC described that "(what) we do, I wouldn't call it primary care, it's more around health services, so we're doing health screenings. And if we identified like a health condition, we're doing care coordination for primary care and then we put them on a care pathway."

Nonetheless, while all interviewees understand the value of offering primary care services directly through their CCBHC, they have chosen not to pursue this approach, primarily because they cannot guarantee consistent demand. One program supervisor communicated that they had heard from others that they "had difficulty keeping a (primary care) clinic in-house busy enough to provide services." Another explained that while "we've definitely had a conversation about bringing in a physician in-house at some point with CCBHC funding," they weren't sure about the patient volume, and so "are looking for a partnership, something that we can do with someone."

Another reason interviewees perceived insufficient demand for maintaining their own primary care clinics was a consistent desire, across interviewees, to prioritize primary care provider choice. As one interviewee explained,

> *"although I'm happy to be one-stop shopping for people, I also really need to enhance the skill that my staff has with coordinating with people who don't want one-stop shopping, who have long-term relationships with their primary care that really don't wanna disrupt those relationships that are quality relationships where they're getting quality care, and we just gotta figure out how to make that work."*

This sentiment was expressed by interviewees from CCBHCs participating in the Section 223 Demonstration—"if that care is being provided, it was more about coordinating the care"—and participants from CCBHCs not participating in the Demonstration—"we also need to make sure we're providing people with choice of provider."

Medication-Assisted Treatment

CCBHCs differ on whether they use their FQHC partner to offer medication-assisted treatment (MAT) services. A few participants shared that their CCBHC offers MAT directly and does not partner with their FQHC or another organization for MAT services. Other clinics offer or plan to offer one type of MAT while the FQHC provides another medication. CCBHC providers then refer patients to the FQHC if the FQHC offered medication is clinically appropriate for or preferential to the patient. Several CCBHCs do not offer MAT directly and partner with their FQHC or another provider for their MAT services despite not having a DCO arrangement, including the CCBHC with a FQHC co-applicant.

FQHC Perspectives

This section describes findings derived from our interviews with representatives from three FQHCs in Michigan. No interviewee was aware of a formal or informal partnership with a CCBHC, but all expressed the importance of partnering with community mental health care to treat higher acuity behavioral health patients. Specifically, interviewees representing FQHCs mentioned that the patient population they primarily refer to community mental health are individuals with serious and persistent mental illness. Indeed, interviewees stressed that they offer integrated care, including behavioral health services, appropriate for treating patients with mild and moderate mental health and substance use disorder conditions. These services include cognitive behavioral therapy and MAT.

Discussion

This study is among the first to examine the structure and purpose of relationships between CCBHCs and FQHCs. To date, no peer-reviewed study has examined the CCBHC model or their mandated arrangements with FQHCs. Given the lack of publicly available data, we employed qualitative methods in the form of semi-structured interviews to explore the relationship between CCBHCs and FQHCs focusing on clinics located in the state of Michigan.

Our interviews suggest that the CCBHC model may have changed the delineation of patients between CCBHCs and FQHCs. Before the CCBHC model was established, most community mental health clinics primarily treated patients with serious and persistent mental illness. Since becoming CCBHCs, these clinics have expanded their patient population to include individuals with mild-to-moderate mental illness and those with substance use disorders. The behavioral health services offered by FQHCs have always targeted patients with substance use disorders and less severe and acute mental health conditions. Thus, CCBHCs and FQHCs now have shared patient populations.

We find that CCBHC–FQHC arrangements primarily serve to facilitate referrals for the types of services each organization does not offer. Specifically, FQHCs refer patients with serious and persistent mental illness to CCBHCs, and CCBHCs refer patients needing primary care services to FQHCs. Individuals with mild and moderate mental illness and substance use disorders are typically served by the organization they initially enter.

The referral utility of CCBHC–FQHC relationships aligns with their overwhelming care coordination structure as opposed to DCO arrangements. The primary purpose of a DCO is to deliver CCBHC required services externally.[9] As the majority of our interviewees elect to meet the CCBHC outpatient primary care screening and monitoring requirement by providing these services directly, it is not surprising that CCBHC–FQHC partnerships gravitate toward a care coordination structure instead of a DCO arrangement.

The finding that the majority of Michigan CCBHCs form non-DCO relationships with FQHCs aligns

with existing research on clinics participating in the Section 223 Demonstration program in other states. The 2020 Assistant Secretary for Planning and Evaluation Report on the CCBHC program finds that an average of 7% of CCBHCs form DCO relationships with FQHCs across states. However, the average percent of CCBHCs across states that form formal or informal non-DCO arrangements, like care coordination agreements, with FQHCs is 82%.[10]

The 2020 Assistant Secretary for Planning and Evaluation (ASPE) report does not shed light on CCBHC–FQHC relationships for organizations not participating in the Section 223 Medicaid Demonstration.[11] Our research suggests that CCBHCs not participating in the Demonstration establish similar care coordination relationships with FQHCs as their peers. We find that the few Michigan CCBHCs without FQHC partners are clinics that only recently received an expansion award in 2021. Further, they all described plans to establish FQHC care coordination partnerships, not DCO arrangements, to enhance their referral relationship.

Our research reveals that CCBHCs value their FQHC partnership, so much so that several expressed interest in expanding these arrangements. Clinics with existing co-location arrangements described discussions regarding expanding the number of shared clinic hours. CCBHCs with partnerships but no co-location or nearby access shared that they were interested in facility sharing. Further, interviewees shared that they do not desire or foresee expanding their services to provide primary care directly. This observation differs from the 2020 ASPE report finding that 55% of CCBHCs provide on-site primary care services in addition to primary care screening and monitoring.[12]

Future Research

Our findings present several opportunities for further examination. First, our finding that, unlike other community mental health clinics, many CCBHCs have a shared patient population with FQHCs requires further examination. Multiple interviewees expressed that the rampant demand for services creates no competition between CCBHCs and FQHCs for patients with less severe and acute mental health conditions. However, other research demonstrates that CCBHCs compete with local providers (e.g., hospitals, schools, other community mental health clinics) to hire and retain limited staff, suggesting that while there may be next to no competition for patients, competition for providers may exist.[13] Only one CCBHC participant described that they experience workforce competition with an FQHC. Specifically, she is losing staff to an FQHC who has the certification needed to provide loan repayment. Future research should explore if provider competition generalizes to other CCBHC–FQHC partnerships.

Our findings on how CCBHCs deliver MAT require further inquiry. We find that Michigan CCBHCs differ on if they offer MAT directly, in combination with their FQHC partner, or through a non-DCO formalized arrangement. This finding stands in conflict with CCBHC federal guidelines. According to the SAMHSA CCBHC criteria, outpatient mental health and substance use services, including MAT for alcohol and opioid substance use disorders, is a service category that CCBHCs are required to offer directly.[14] However, the recently released handbook for Michigan CCBHCs participating in the Section 223 Demonstration allows CCBHCs to provide outpatient mental health and substance use services, including MAT for alcohol and opioid substance, either directly or through a DCO arrangement.[15] Future research should examine why Michigan CCBHC criteria diverge from SAMHSA federal criteria, and what this means for the delivery of MAT services.

We observe that no CCBHC–FQHC partnership involves EHR integration, though some arrangements include shared EHR access. Future qualitative work should explore the barriers to EHR integration and data sharing. Further, in-depth case studies of select relationships that have successfully integrated their EHRs may prove useful to clinics interested in EHR integration.

Limitations

This study has several limitations. First, we interviewed only a subset of 13 CCBHCs, representing 37% of organizations in Michigan. Though it is possible that the CCBHCs not included in our study differ from our participants, we addressed this potential limitation through our sampling approach. Specifically, we achieved both geographic and federal program diversity by ensuring that we interviewed at least 25% of clinics from the three clinic types based on federal program participation, as well as 25% of clinics in each PIHP with the exception of two PIHPs. Further, we interviewed CCBHCs until saturation was reached.

Another significant concern is the fact that we were only able to interview three FQHCs. It is likely that the FQHCs who did not respond to our interview request have differing opinions, and perhaps more negative or strong perceptions, about the CCBHC model and CCBHC–FQHC arrangements. Thus, future research should further explore the FQHC perspective.

Second, we only interviewed organizations residing in Michigan. Michigan provides an interesting case to begin to examine relationships between CCBHCs and FQHCs owing to the presence of organizations that participate in the Section 223 Medicaid Demonstration and received a SAMHSA Expansion award and clinics who participate in one but not both federal programs. However, Michigan may prove unique compared with other states.

Michigan uses a managed care delivery structure involving PHIPs who contract with community mental health service programs and other non-profit providers to provide behavioral health care. Specifically, PIHPs receive capitated Medicaid funds based on the number of Medicaid beneficiaries in their service area. They then directly pay community mental health clinics and other providers from these funds. Thus, since Michigan already had a capitation system in place, advocates and providers communicated that they suspect the experience of clinics newly receiving the prospective payment rate through the Section 223 Demonstration may be distinct from clinics in other states that did not have a capitated system prior. For this reason, we caution against any generalizations to CCBHC–FQHC arrangements outside of Michigan.

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